

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004972	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/31/2015
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The visit was for investigation of a State complaint.</p> <p>Complaint Number: IN00174338</p> <p>Substantiated: No deficiencies related to the allegations are cited.</p> <p>Date 12-30/31-15</p> <p>Franciscan St Francis Health-Indianapolis is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.5-10, Utilization review and discharge planning services, Indiana Hospital Licensure Rules.</p> <p>QA: cjl 02/17/16</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE